INTERVAL HISTORY FORM

BROOKHAVEN NATIONAL LABORATORY
Occupational Medicine Clinic
Upton, New York 11973-5000

OMC CHART #: _____
Pre Placement _____ **Recheck**____
Termination _____ **Other**_____

TO UPDATE YOUR RECORD **SINCE YOUR LAST EXAMINATION AT OUR CLINIC,** PLEASE COMPLETE THE FOLLOWING TWO PAGES

PERSONAL INFORMATION

Mr. Mrs. Ms. Miss Dr.

Name: Last_____ First_____ Middle_____

Home address: Street: _____ City:_____ Zip code:_____

Home phone: _____ Sex: M F Date of Birth:_____

NEXT OF KIN (or person to contact in emergency): Name:_____

Relation:_____ Phone#_____

FAMILY DOCTOR: Name: _____ Phone#_____

Address:_____

WORK DATA: BNL Life No: _____ Job Title:_____

Type of work:_____ Laboratory Address:_____

Dept./Div.:_____ Phone Ext.:_____ Supervisor:_____ Supervisor Ext.:_____

MEDICAL INFORMATION

ALLERGIES:
Do you have any known allergies? ____ No ____ Yes If Yes, please explain:_____

MEDICATIONS:
Are you currently taking any medications on a regular basis (including vitamins/alternative medications)? ____No ___Yes

If Yes, please complete the following:

Name of Medication	Dose	For What Condition

OCCUPATIONAL HISTORY: Do you have any unreported occupational injuries or illnesses? ____ No ____ Yes

If Yes, explain:_____

SOCIAL HISTORY: Has there been any significant change in your social/lifestyle habits (exercise, travel, hobbies, pets and/or alcohol use) since your last visit? ____ No ____ Yes

If Yes, explain:_____

HEALTH PROMOTION:
Please circle those BNL activities you may have attended since your last visit:

Wt. Watchers Smoking Cessation Dietician Consult Exercise Consult None Other:_____

SMOKING HISTORY:

SMOKING HISTORY	PACKS PER DAY	AGE/YEAR STARTED	AGE/YEAR STOPPED
NEVER SMOKER	________	________	________
CURRENT SMOKER			________
EX-SMOKER			
CIGAR SMOKER	________		
PIPE SMOKER	________		
CHEWING TOBACCO	________		

FAMILY HISTORY:

Has there been any significant new family illness or event? ____ No ____ Yes If Yes, explain: ______________________

MEDICAL HISTORY:

Please identify below any circumstances that may apply to you since your last visit at the Occupational Medicine Clinic.

	YES	NO	APPROXIMATE DATE
HOSPITALIZATIONS			
SURGERIES			
INJURIES			
ILLNESSES			
DIAGNOSED WITH CANCER			
OTHER HEALTH EVENTS			

Please provide details for any items identified above: ____

____

Current symptoms or health concerns:____

____

Do you have any concerns about safely performing your job? : ____

____

I certify that the information provided is complete and accurate.

***Signature:** ______________________________ **Date:** ______________________

*A sample of your signature is required should you ever request information from your record by written authorization.

DO NOT WRITE BELOW THIS LINE–PHYSICIAN USE ONLY

★ ★

The above information has been reviewed with the employee and recommendations have been made and advised as appropriate.

Physician initials:__________________ Date:______________________

Was a records release requested for neoplasm information or hospitalizations if we do not have on file? YES NO REFUSED

EXAMINEE - DO NOT FILL IN: FOR OFFICE USE ONLY

BROOKHAVEN NATIONAL LABORATORY
OCCUPATIONAL MEDICINE CLINIC

Physical Examination Form:

Pre-Placement:_____ Recheck:_____

Termination:_____ Other:_____

Name:_____

Chart #:_____

Date:_____

Age:_____ Extension:_____

BP:	**Pulse:**			**Height:** Ft: In: Cm:		**Weight:** Lbs: Kg:			**Tonometry:** OS= OD=
	WNL	Other	Not Exam'd	Remarks		WNL	Other	Not Exam'd	Remarks
General Appearance					Breasts				
Head					Genitalia				
Eyes					Rectal				
Fundi					Spine				
Ears/Nose					Extremities				
Mouth/Teeth/Throat					Lymph Nodes				
Neck/Thyroid					Peripheral Vascular				
Lungs					Neurologic				
Heart					Psychiatric				
Abdomen					Skin				
Hernia					Other				

Interval History/ROS: _____

_____

_____

Impression/Plan: _____ No pathology noted

PPD: _____ Known (+) _____Not Indicated _____ Offered _____ Accepted _____Declined

Chest X-ray _____Indicated _____Not Indicated _____Declined

Screening recommendation sheet given? ___Yes __ No Discussed medical evaluation and diagnostic test results? __ Yes __ No

_____, Staff Clinician _____Date